

## Disability Consultation / Representation Referral to Kansas Legal Services

☐ Adult

☐ Child

Adult/Child's Name: \_\_\_\_\_ SRS Case Number: \_\_\_\_\_ SSN: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/ State : \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ County of Residence: \_\_\_\_\_  
**Alternative Contact Information for Client:** Telephone: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
Referred by (Name/Title): \_\_\_\_\_ Agency/SRS office: \_\_\_\_\_ Telephone: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Date Referred to KLS: \_\_\_\_\_  
Medical Statement(s) Attached: Yes \_\_\_\_\_ No \_\_\_\_\_  
Program Type: ☐ TAF ☐ CINC: ☐ Fam. Pres. ☐ Fam. Serv. ☐ Emerg. Shelter: ☐ Other: ☐

### FOR CHILDREN ONLY:

The following information will help in determining if the child has a physical or mental problem and could receive SSI. (Please check any that apply.)  
Remember to consider the child's age--inability to do an activity is a problem only if he or she should be capable of it at that age. Does the child have problems:

Communicating \_\_\_\_\_ Feeding \_\_\_\_\_ Playing \_\_\_\_\_ With turning \_\_\_\_\_ Understanding Speech \_\_\_\_\_  
Walking \_\_\_\_\_ With Head Control \_\_\_\_\_ Washing \_\_\_\_\_ Socializing \_\_\_\_\_ Using the bathroom \_\_\_\_\_  
Going to School \_\_\_\_\_ With School Performance \_\_\_\_\_ Speaking \_\_\_\_\_ Crawling \_\_\_\_\_ Other \_\_\_\_\_  
Swallowing \_\_\_\_\_ Eating \_\_\_\_\_ Dressing \_\_\_\_\_ Paying Attention \_\_\_\_\_ Explain: \_\_\_\_\_  
Is the child in a special education class? Yes \_\_\_\_\_ No \_\_\_\_\_ Is the child in a special needs school? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has an SSI application ever been made for the child? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when \_\_\_\_\_ Results: \_\_\_\_\_  
Are parental rights severed on this child? Yes \_\_\_\_\_ No \_\_\_\_\_ Are there reports of child abuse or neglect on file? Yes \_\_\_\_\_ No \_\_\_\_\_

### Authorization to Release Information:

Now on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, I \_\_\_\_\_

hereby consent and authorize the State Department of Social and Rehabilitation Services to release any and all records and information in their possession, control, and custody to Kansas Legal Services for the purpose of providing advice and/or representation concerning the above named client's Social Security disability claim. I release the State Department of Social and Rehabilitation Services from any liability for giving such information.

I also consent and authorize Kansas Legal Services to release any and all records and information in their possession, control, and custody concerning advisement and/or representation of the above named client's Social Security disability claim to the State Department of Social and Rehabilitation Services for purposes of program administration, monitoring, and evaluation of the Social Security Disability Advocacy Project. I release Kansas Legal Services from any liability for giving such information.

Client (Parent/Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_